Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number:
M4-12-2318-01

MDR Date Received:
MARCH 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not informed in time for service."

Amount in Dispute: $195.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor is seeking copay reimbursement of $100.00, $20.00, and $13.00 respectively for the above services. According to DWC Rule 140.8(e)(1)(E) "…The workers' compensation insurance carrier must give notice of its response to the reimbursement request to the injured employee and the health care provider that performed the services that are the subject of the reimbursement request. If the claim is compensable, the notice shall include an explanation that the claim is compensable and that the health care provider must reimburse the injured employee for any amounts paid to the health care provider by the injured employee." Notice was given to Dr. N. Johnson on 9/27/11. (Attachments) Therefore, Dr. Johnson and the requestor have been notified that Dr. Johnson should reimburse the requestor the copay given on 7/11/11. Because no billing has been received for the services provided by Dr. Pearce or the Heart Hospital, notice to them and the requestor has not been given. For this reason the requestor cannot seek reimbursement from them for the copays made on 7/5/11 and 7/21/11. The requestor also seeks reimbursement of copays made to Walgreens #5160 on 7/6/11, and 7/11/11 in the amount of $40.00 total for three prescriptions of hydrocodone and one prednisone. Notice was given to Walgreens #5160 on 9/28/11. (Attachments) As a result, Walgreens #5160 and the requestor have been notified that Walgreens #5160 should reimbursement the requestor the copays given on 7/6/11 and 7/11/11."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 5, 2011 July 6, 2011 July 11, 2011 July 21, 2001	Out-of-Pocket Expenses incurred by Injured Employee Heart Hospital of Austin - $100.00 – co-pay Prescription Meds - $20.00 – co-pay Dr. N. Johnson - $20.00 – co-pay Dr. J. Pearce - $35.00 – co-pay Prescription Meds - $20.00 – co-pay	$195.00	$195.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 27, 2011

- 100 – Payment Made to patient/insured/responsible party/employer.
- 3 – Co-payment amount.
- 875 – Copay was paid under private insurance. Seek refund from provider, Workers' Compensation Insurance not liable for copay per Rule 140.8(E).
- 908 – Employee may only pursue reimbursement for medical in the amount payable under 133.270.

Findings

In accordance with 28 Texas Administrative Code §180.8(e)(8)(E) Texas Mutual Insurance Company gave notice of its response to the reimbursement request to the injured employee and health care provider that performed the services. According to the response received by the insurance carrier, notice was given to Dr. N. Johnson on September 27, 2011 and Walgreens #5160 on September 28, 2011. The insurance carrier did not give notice to Dr. Pearce of the Health Hospital of Austin as no billing has been received for the service provided by these to entities. The insurance carrier goes on to state, "For this reason the requestor cannot seek reimbursement from them for the copays made on 7/5/11 and 7/21/11.

The injured worker was contacted in regards to the notices given to Dr. Johnson and Walgreens #5160. Neither healthcare provider has reimbursed the injured worker as of January 14, 2013. Therefore, reimbursement in the amount of $195.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $195.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $195.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		January 18, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.